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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

13. PRIVATE DUTY NURSING SERVICES: Prevailing community rate, subject to Department verification prior to approving charge.

14. INDEPENDENT SPEECH, OCCUPATIONAL AND PHYSICAL THERAPIST SERVICES: Same as 6.

15. HEALTH MAINTENANCE ORGANIZATION SERVICES: Flat monthly rate per enrolled client as established by the Department.

16. APPLIANCES/PROSTHESES: Most reasonable cost for the item which will adequately meet the client's needs. Most reasonable cost is based on the lowest of two or three estimates given prior to purchase.

17. MEDICAL SUPPLIES AND EQUIPMENT: Medical Supplies - Reimbursed at Department's maximum rate (cost plus 50%). Medical Equipment - Lowest price available in the geographic area where the client resides.

18. TRANSPORTATION: Lesser of charges or Department maximum. Ambulance, medicar and service car provides: base rate plus mileage rate; oxygen add-ons may be reimbursed when provided in ambulance or medicars. Commercial carrier transportation is approved on case-by-case basis and reimbursed at the prevailing or a negotiated rate.

19. FAMILY PLANNING: Variable maximum per visit category: initial visit, annual visit, routine visit, problem visit and supply visit.

20. HEALTHY KIDS SERVICES: (Early and Periodic Screening, Diagnosis and Treatment): Variable maximum depending upon provider type: hospital outpatient clinic facility - Department approved outpatient rate; encounter rate clinic - Department approved visit rate; physician visit - Department approved rate(s).

10/91 21. REHABILITATIVE SERVICES:

Mental Health Services

7/96 a. The amount approved for payment of mental health rehabilitative services shall be based on the type and amount of service required by a client. The amount is determined in accordance with prospective rates developed by the Illinois Department of Mental Health and Developmental Disabilities (DMHDD) or the Department of Children and Family Services (DCFS) and as adopted by the Illinois Department of Public Aid for Medicaid reimbursable services. The rates are prospective without reconciliation. The adopted rate shall not exceed the charges to the general public.

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=7/96 b. Rates are cost based and are established annually for each service. In order that costs may be determined, each provider shall submit, upon application for certification and annually thereafter, an annual audit for the prior fiscal year and two copies of the required statistical and financial information which shall be submitted on forms specified by DMHDD or DCFS. Rates will be developed through the application of formal methodologies specific to each category.

7/96 i. Outpatient community-based services are reimbursed at an all-inclusive per client hour rate payable to the nearest quarter hour for services actually delivered. The service hourly rate is calculated as the sum of all appropriate costs divided by available time to provide billable direct care. Appropriate costs are the sum of three components:

A. Annual staff salary (or wages);

B. The proportion of annual overhead costs necessary for the direct care staff person to perform duties. Overhead costs include non-salary program costs, administration, support, and occupancy/building related costs; and

C. The annual cost of paid benefits for a direct care staff person.

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7/96 D. Available time to provide billable direct care is the remainder of annual direct care staff working hours minus annual direct care staff non-billable hours. Annual direct care staff working hours is the product of: average length of a work day and the remainder of total annual service days for ~~a~~ direct care staff position minus the average number of paid non-work days per year for direct care staff (i.e., vacation, holidays and sick days).

Annual direct care staff non-billable hours is time necessary for providing direct care but which is not, in itself, a billable activity. It includes such activities as staff development (training and coordination), preparation for and documentation of services, client no-shows and missed appointments, and non-billable collateral contacts. It is the product of annual direct care staff working hours and a statewide standard (proportion) of time required for necessary but non-billable indirect activities.

E. The hourly rates developed for outpatient community-based services vary by service, depending upon three additional conditions:

1. The staff position that will deliver the actual service (QMHP,MHP,RSA);

~~1.~~2. The ratio of staff to clients in the service; and

~~2.~~3. The service requires staff availability seven days a week, twenty-four hours per day (crisis services).

ii. A premium factor is applied for offsite outpatient community-based services. This factor compensates providers for staff time necessary for travel to off-site treatment locations. It is a supplemental proportion added to the basic hourly rate of any service the State determines may be provided off-site.

7/96 iii. Residential rehabilitation services are reimbursed at an all-inclusive per diem rate payable for services delivered in accordance with the client's treatment plan. A unique per diem will be developed for each provider under contract to deliver residential rehabilitation services. Each per diem calculation will vary based on the amount of direct care workers' salaries, the program staffing ratios, the amount of allowable overhead costs and other cost variables. Programs designed to service the most difficult clients will have the higher per diems due to a greater number of QMHPs on payroll. The ratio of direct care staff to clients will also be higher in programs serving difficult children.

7/96 The per diem rates are computed based on a detailed rate methodology that excludes room and board costs. The rate methodology is outlined in a master document, Residential Rehabilitation Services Rate Methodology, dated June 26, 1997, and is on file with the Department of Children and Family Services' Federal Claiming Unit.

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Alcoholism and Substance Abuse Treatment:

7/97 a. Rates are prospective and are established annually for each service. In order that costs can be analyzed for a determination of rate, each provider shall submit, upon application for certification, an annual audit for the prior two fiscal years and two copies of the required statistical and financial information on a form specified by the Department. Rates are developed through the application of formal methodologies specific to each category of service. These methodologies are contained in the Department's "Methodologies For the Purchase of Individual Alcohol and Other Drug Abuse Treatment Services (July 1997)" manual. In all cases, the established rate shall not exceed the charges to the general public.

7/97 b. Outpatient (Level I), Intensive Outpatient (Level II), Residential Rehabilitation (Level III) and Day Treatment (Level III) rates are considered "all-inclusive", accounting for all reasonable expenses associated with full delivery of a comprehensive array of all clinically-necessary and routinely delivered service elements. The rate is calculated as the sum of the following cost components: Program, Support, Capital, Administration, and Transportation. Level III services are billed per diem.

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7/97 c. For Level I and II services, a uniform reimbursement rate is determined based upon normative data comprised of calculated rates for each provider. The median of the individual rates is the basis for the final calculation of the uniform rate. The individual rate for each provider is determined by calculation based upon statewide salary data, staffing and programmatic requirements, workload assumptions, allowances for fringe benefits, clinical training, and program supplies as well as statewide normative data for support, capital and transportation costs.

7/97 d. For Level III services, Residential Rehabilitation and Day Treatment, an individual rate is established for each program. A per diem rate is calculated based upon statewide salary data, staffing and programmatic requirements, workload assumptions, allowances for fringe benefits, clinical training, and program supplies as well as statewide normative data for support, specific individual capital component costs, transportation and administrative. Separate calculation models have been established for different bed sizes in order to account for varying economies of scale, beginning at 10 beds and increasing in 5 bed increments. The residential rehabilitation models also distinguish between adult and adolescent programs. The calculated rate for day treatment excludes domiciliary costs. Payment for Level III services does not include payment of room and board charges.

7/97 e. Psychiatric diagnostic services are reimbursed on a per encounter basis to psychiatrists at the practitioner's usual and customary charge, not to exceed the maximum established by the Department of Public Aid.

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10/91 CLINIC SERVICES

4/98 Mental Health Services

The amount approved for payment of mental health clinic services shall be based on the type and amount of service required by and actually delivered to a client. The amount is determined in accordance with the prospective rates developed by the Department of Mental Health and Developmental Disabilities and as adopted by the Department of Public Aid for Medicaid reimbursable services. The adopted rate shall not exceed the charges to the general public.

The amount approved for payment of mental health clinic services shall be based on the type and amount of service required by and actually delivered to a client. The amount is determined in accordance with the prospective rates developed by the Department of Mental Health and Developmental Disabilities and as adopted by the Department of Public Aid for Medicaid reimbursable services. The adopted rate shall not exceed the charges to the general public.

7/96 Rates are cost based and are established annually for each service. In order that costs may be determined, each provider shall submit, upon application for certification and annually thereafter, an annual audit for the prior fiscal year and two copies of the required statistical and financial information which shall be submitted on forms specified by DMHDD or DCFS. Rates will be developed through the application of formal methodologies specific to each category.

1) Clinic services are reimbursed at an all-inclusive per client hour rate payable to the nearest quarter hour for services actually delivered. The service hourly rate is calculated as the sum of all appropriate costs divided by available time to provide billable direct care. Appropriate costs are the sum of three components:

- Annual staff salary (or wages);
- The proportion of annual overhead costs necessary for the direct care staff person to perform duties. Overhead costs include non-salary program costs, administration, support, and occupancy/building related costs; and
- The annual cost of paid benefits for a direct care staff person.

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7/96 a) Available time to provide billable direct care is the remainder of annual direct care staff working hours minus annual direct care staff non-billable hours. Annual direct care staff working hours is the product of: average length of a work day and the remainder of total annual service days for a direct care staff position minus the average number of paid non-work days per year for direct care staff (i.e., vacation, holidays and sick days).

Annual direct care staff non-billable hours is time necessary for providing direct care but which is not, in itself, a billable activity. It is the product of annual direct care staff working hours and a statewide standard (proportion) of time required for necessary but non-billable activities.

b) The hourly rates developed for clinic services vary by service, depending upon three additional conditions:

- The staff position that will deliver the actual service (QMHP,MHP,RSA);
- The ratio of staff to clients in the service; and
- The service requires staff availability seven days a week, twenty-four hours per day (crisis services).

4/98 School Based/Linked Clinics

Services provided in school based/linked clinics are reimbursed fee for service in accordance with the methods and standards in Attachment 4.19-B. The clinic bills for services provided by the individual practitioner, using the clinic's provider number. The clinic is then reimbursed for services provided. The clinic will be reimbursed at their usual and customary rate or the rate established by the Department, whichever is lower. For example, physician services will be reimbursed as described in Attachment 4.19-B 7 and family planning services as described in 4.19-B 19. Federally qualified health centers located in the school will continue to be reimbursed as FQHCs, in accordance with the methodology described in Attachment 4.19-B 2. The FQHC is not eligible for additional reimbursement as a school based/linked clinic.

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7/93 7/93 Special Rehabilitation Services

10/96 Reimbursement is on a fee-for-service basis. Payment will be the lesser of charge or fee screen using a uniform fee schedule. A maximum fee schedule is developed. The maximum fee schedule is reviewed and specific rates may be adjusted downward or upward so that the rate included in the uniform fee schedule is comparable to other provider fee schedule rates for similar services. Adjustments will not result in reimbursement rates below the amount necessary to ensure access to services.

10/96 The maximum fee schedule rates are based either on 1993 statewide expenditure data maintained by the Illinois State Board of Education or on 1994 expenditure, staffing and service provision data from a statewide representative sample of community providers. The maximum fee schedule accounts for the resources necessary to deliver services including overhead. Consistent use of statewide expenditure date will avoid duplication of direct and indirect cost categorization. Direct and indirect costs may be identified by an approved cost allocation plan for any relevant community-based provider. These direct and indirect costs will not be included in the cost allocation plan for school-based services.

The value of educational resources will be excluded from rate determination.

10/96 The maximum fee schedule determination is consistent with Medicare reimbursement principles detailed in 42 CFR Part 413 Subparts A through G and the Office of Budget and Management Circular A-87. The methodology used is within the upper limits of payment set in 42 CFR 447.321 and 447.325 for outpatient hospital services and clinic services and other inpatient and outpatient facilities.

The maximum fee screen (FS) for each covered service is calculated using the formula:

$$FS = \frac{(DR) + (IR)}{(AH)} \times SH$$

DR = Annual direct health resources including staff and supplies
IR = Annual indirect resources as determined by application of an indirect cost rate analysis schedule to direct resources
AH = Annual service hours of care possible related to direct and indirect resources
SH = Hours of care per individual covered service

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The uniform fee schedule may be adjusted annually, either upward or downward, based on the DRI medical inflation index. Adjustment of the uniform fee schedule will not result in reimbursement rates below the amount necessary to ensure access to services.

The payment differential between individual and group service rates is based on the most current published version of Medicare's Resource Based Relative Value Scale (RBRVS) relative value units (RVUs).

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~~23~~22. HOSPICE PAYMENT RATES: When the individual resides in a long term care facility, the Department shall provide payment of an add-on amount to the hospice for routine home care and continuous home care days at 95% of the facility's per ~~diem~~ rate established in accordance with procedures contained in the Medicaid State Plan and Attachment 4.19-D.

~~24~~23. NURSE-MIDWIFE PAYMENTS: Payments will be made according to a schedule of statewide pricing screens established by the Department of Public Aid, with the exception that a nurse-midwife being reimbursed for covered services at 70% of the established screen. The pricing screens are to be established based on consideration of the market value of the service.